DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OFFICIAL FILE COPY

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 5
2. STATE: Texas
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.40

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ -0-
b. FFY 2002 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attachment

10. SUBJECT OF AMENDMENT: Amendment No. 600 modifies the nursing facility (NF) reimbursement methodology related to the enhanced direct care staff rate.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Linda K. Wertz

13. TYPED NAME:
Linda K. Wertz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 20, 2001

16. RETURN TO:
Linda K. Wertz
State Medicaid Director
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 21 SEPTEMBER, 2001

18. DATE APPROVED: 24 OCTOBER, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 JULY, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Calvin G. Cline

21. TYPED NAME:
CALVIN G. CLINE

22. TITLE: ASSOICATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Calvin G. Cline
Associate Regional Administrator, Medicaid and State Operations

1301 Young Street, Room 827
Dallas, Texas 75202
Phone (214) 767-6301
Fax (214) 767-0270

October 24, 2001

Our reference: SPA-TX-01-05

Ms. Linda K. Wertz, State Medicaid Director
Texas Health and Human Services Commission
Post Office Box 13247
Austin, TX 78711

Dear Ms. Wertz:

We have reviewed the proposed amendment to your Medicaid State plan submitted under transmittal no. (TN) 01-05. Effective July 1, 2001, this amendment revises the nursing facility reimbursement methodology relating to the enhanced direct care staffing rate. A provision has been added to allow the collection of interest for overpayments made to nursing facilities that fail to maintain their required staffing levels. Also, an entity that controls more than one facility may have its compliance evaluated in the aggregate for all facilities it controls.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13)(A) and 1902(a)(30) of the Social Security Act and the implementing federal regulations at 42 CFR 447 Subpart C. We have approved the amendment for incorporation into the official Texas State plan effective on July 1, 2001. We have enclosed a copy of HCFA-179, transmittal no. 01-05, dated October 24, 2001, and the amended plan pages.

If you have any questions, please call Billy Bob Farrell at (214) 767-6449.

Sincerely,

Calvin G. Cline

Calvin G. Cline
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosures

cc: Elliot Weisman, CMSO, PCPG
Commerce Clearing House

Attachment to HCFA-179 for
Transmittal No. 01-05, Amendment 600

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Attachment 4.19-D	Attachment 4.19-D
Page 6	Page 6 (TN00-07)
Page 6b	Page 6b (TN00-07)
Page 6d	Page 6d (TN00-07)
Page 6f	Page 6f (TN00-07)

(VI) Enhanced Direct Care Staff Rate.

(A) Direct care staff cost center. This cost center will include compensation for employee and contract labor Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), medication aides, and nurse aides performing nursing-related duties for Medicaid-contracted beds. Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess.

(B) Rate year. The standard rate year begins on the first day of September and ends on the last day of August of the following year.

(C) Enrollment. An initial enrollment contract amendment is required from each facility choosing to participate in the enhanced direct care staff rate. Participating and nonparticipating facilities may request to modify their enrollment status during any open enrollment period. Enrollment begins on the first day of July and ends on the last day of that same July preceding the rate year for which payments are being determined. Should conditions warrant, additional enrollment periods may be conducted during a rate year. Facilities, which did not submit an enrollment contract amendment by the last day of the open enrollment period, will continue at the level of participation of the previous year within available funds.

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(2) Enhanced staffing levels. Participating facilities desiring to staff above the minimum requirements from (VI)(D)(1) may request LVN equivalent staffing enhancements from an array of LVN equivalent enhanced staffing options and associated add-on payments during enrollment. Enhanced staffing options offered are based upon multiples of one LVN equivalent minute.

(3) Granting of staffing enhancements. All requested enhancements are divided into two groups: pre-existing enhancements that facilities request to carry over from the prior year and newly-requested enhancements. Newly-requested enhancements may be enhancements requested by facilities that were nonparticipants in the prior year or by facilities that were participants in the prior year desiring to be granted additional enhancements. Using the process described herein, the distribution of pre-existing enhancements is determined. If funds are available after the distribution of pre-existing enhancements, the distribution of newly-requested enhancements is determined.

(a) For each enhancement option, projected units of service for facilities requesting that option are determined and multiplied by the rate add-on associated with the option as determined in (VI)(F)(2).

(b) The sum of the products from subparagraph (VI)(D)(3)(a) is compared to available funds.

(c) If the product is less than or equal to available funds, all requested enhancements are granted.

(d) If the product is greater than available funds, enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds.

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(F) Determination of direct care staff rates for participating facilities. Direct care staff rates for participating facilities will be determined as follows:

(1) Determine the direct care staff rate associated with maintaining direct care staff minutes at the minimum levels required for participation.

(a) Determine the sum of recipient care costs from the direct care staff cost center in all nursing facilities as included in the initial database from (VI)(E)(1).

(b) Adjust the sum from (VI)(F)(1)(a) to inflate the costs to the prospective rate year as per (III)(D).

(c) Divide the result from (VI)(F)(1)(b) by the sum of recipient days of service in all facilities in the initial database from (VI)(E)(1) and multiply the result by 1.07. The result is the average direct care staff rate associated with maintaining direct care staff minutes at the minimum levels required for participation.

(d) Case-mix adjustment of direct care staff per diem rate component. To calculate the direct care staff per diem rate component associated with maintaining direct care staff minutes at the minimum levels required for participation for each of the 11 TILE case-mix groups and for the default group, multiply each of the standardized statewide case-mix indexes associated with the initial database from (VI)(E)(1) by the average direct care staff rate component from (VI)(F)(1)(c).

(e) The initial database from (VI)(E)(1) used in determining the direct care staff rates will not change, except for adjustments for inflation from (VI)(F)(1)(b). HHSC may also recommend adjustments to the rates when new legislation, regulations, or economic factors affect costs and these effects are not accounted for in the initial database or the inflationary adjustments. For example, a change in the minimum wage would not immediately be accounted for in the inflationary adjustments. In such a situation, the commission will project costs associated with new legislation, regulations, or economic factors according to the methodology at (III)(D).

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(G) Staffing accountability. Participating facilities will be responsible for maintaining the staffing levels determined in (VI)(D). Participating facilities that fail to maintain staffing at their required level will have their direct care staff rates and staffing requirements adjusted to a level consistent with the highest staffing level that they actually attained and all direct care staff revenues associated with unmet staffing goals will be recouped by HHSC or its designee. Participating facilities that fail to meet the minimum direct care staff requirements for participation will be removed from participation. Facilities removed from participation may re-enroll in the enhanced direct care staff rate during the next enrollment period. Re-enrollments for facilities previously removed from participation are treated as newly-requested enhancements as per (VI)(D)(3) above. Participating facilities that fail to maintain their required LVN equivalent minutes by two or more LVN equivalent minutes will have these adjustments remain in effect for the longer of either the remainder of the rate year in which the determination is made plus another full rate year or until the first day of the rate year after funds identified for recoupment are repaid. Interest will be collected from participating facilities that fail to maintain their required LVN equivalent minutes by two or more LVN equivalent minutes as follows:

(1) Determine the average excess funds available to the provider over the reporting period as the staffing recoupment amount divided by two.

(2) Determine the annualized average three-month United States Treasury Bill rate during the provider's reporting period as the unweighted monthly average for all months included, either partially or fully, in the reporting period.

(3) Determine the interest rate on the recoupment amount by multiplying the annualized average rate from (2) above by the number of days in the reporting period divided by the number of days in the rate year.

(4) Determine the interest on the recoupment amount by multiplying the recoupment interest rate calculated in (3) above by the average excess funds available to the provider over the reporting period from (1) above.

(H) Spending requirements for all facilities. All facilities, participants and nonparticipants alike, are subject to a direct care staff spending requirement with recoupment calculated as follows:

(1) At the end of the facility's rate year, a spending floor will be calculated by multiplying accrued Medicaid direct care staff revenues by 0.85.

(2) Accrued allowable Medicaid direct care staff expenses for the rate year will be compared to the spending floor from (VI)(H)(1). HHSC or its designee will recoup the difference between the spending floor and accrued allowable Medicaid direct care staff expenses from facilities whose Medicaid direct care staff spending is less than their spending floor.

(3) In cases where a responsible entity controls more than one nursing facility contract, the responsible entity may request to have its contracts' compliance with the spending requirements evaluated in the aggregate for all contracts it controlled at the end of the rate year or at the effective date of the change of ownership or termination of its last nursing facility contract.

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